Care Standards

The Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care) Rules 2008

[2018] 3541.EA-MoU

Before

Ms Siobhan Goodrich (Judge)
Ms Caroline Joffe (Specialist Member)
Mrs Wendy Stafford (Specialist Member)

Heard on 22, 23, 24 with panel deliberations on 30 January 2019

B E T W E E N

THE STAUNTON GROUP PRACTICE

Appellant

and

CARE QUALITY COMMISSION

Respondent

DECISION AND REASONS

Representation:
The Appellant: Dr Ogunsanya, solicitor advocate, Taylor Wood Solicitors
The Respondent: Mr A Dos Santos, counsel, instructed by Ward Hadaway

The Appeal

1. This is an appeal brought under section 32 (1) (b) of the Health and Social Care Act 2008 (the Act) by the Appellant against the decision made by a Justice of the Peace who, on 6 November 2011, made an order under Section 30 of the Act cancelling the registration of the Staunton Medical Practice on an urgent basis.

2. The Appellant is the Staunton Group Practice which was first registered by the CQC on 1 April 2013 as a service provider to carry out the regulated activities in the following area: Diagnostic and screening procedures, Family planning, Maternity and midwifery services, Surgical procedures, and Treatment of disease, disorder or injury at Morum House Medical Centre in Wood Green, London. The most recent certificate issued on 17 December 2015 included as a condition of registration that the membership of the practice is as follows: Drs Agoe, Dr Ali, Dr B and Dr S. The practice has some 15,500 patients.

3. We were informed at the outset by Dr Ogunsanya that he was instructed by Drs Agoe and Ali. He was not instructed by the other registered partners.

4. Reference to "the Appellant" in this decision should be taken to refer to registered service provider: the Staunton Medical Practice. For practical purposes this means Drs Agoe and Ali. They are the members of the practice who seek a different outcome regarding the decision to cancel registration under appeal before us.

Restrictions on Reporting

5. No application was made by either party for a restricted reporting order under Rule 14(1) (a) and (b) of the 2008 Rules. That being so, a restriction on reporting would not ordinarily be required.

6. In his final submissions, however, Dr Ogunsanya stated that there was no evidence that the other doctors in the partnership were aware of the order made, or the fact of the appeal. This has not been mentioned before. Dr Ogunsanya sought also, in his final submissions, to rely on arguments regarding the Article 8 rights of one doctor in particular, by whom he was not instructed. In our view this was a surprising development that arose very late in the day. We will return to this in due course in so far as necessary. Suffice to say that, in the course of our consideration of the merits of the appeal brought before us, we decided that it was appropriate in the interests of justice to anonymise the names of the other registered partners. Whilst this may be an excess of caution, no harm to the public interest in transparency is involved by this very limited exercise in the restriction of publication of names, on a protective basis, in the particular and unusual circumstances of the appeal before us.

The Background and Chronology

7. The following account of the background facts is taken from the Scott Schedule prepared by the Respondent:
   a) Following an announced comprehensive inspection on 25/8/15, the CQC served requirement notices under regulations 12 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the Regulations), having identified breaches relating to Safe care and treatment and Fit and proper persons employed. At an announced follow up inspection on 11/5/16, the practice was found to have taken sufficient action to comply with the two regulations.

   b) On 11/9/17, the CQC issued warning notices pursuant to regulations 12 and 17.

   c) The CQC produced a report dated 19/10/17 following comprehensive inspection visits to the practice on 26/7/17 and 1/8/17 with a team of specialist advisers. The Overall rating was 'inadequate'. The rating was inadequate in each category/domain save for 'are services caring?' which was recorded as 'requires

improvement'. Significant concerns relating to Safe care and treatment and Good governance were identified. The practice was placed in special measures as from 19/10/17 and warning notices under regulations 12 and 17 were issued.

d) A report dated 8/1/18 was prepared following a focussed inspection on 8/11/17 with a GP specialist adviser. The warning notices were withdrawn and further objectives set for the practice.

e) Under cover of email dated 4 April 2018, the Appellant emailed the CQC three applications for: registration of Dr Agoe as Manager; removal of Dr B as a Partner as of 31/3/18; removal of Dr S as Partner as of 30/6/18. On 10/4/18 the CQC rejected the applications to remove Dr Band Dr S because of name error. The Appellant then emailed the CQC the amended/re-issued applications of Drs B and St. Those applications were not to take effect until 30/6/18 (Dr St's leaving date) as the CQC system only allows for de-registering a joint application at the same time.

f) On 3/5/18 the Practice registration was suspended. A report dated 13/8/18 was prepared following an announced comprehensive inspection on 2/4/2018 and 4/5/18. The inspection team included a GP specialist adviser, a nurse specialist adviser a practice manager specialist adviser and a second CQC inspector. The findings were that the practice was inadequate overall and in each and every category/domain. Significant concerns arose in relation to patient safety and the CQC took action to urgently suspend the practice's registration for six months with effect from 9/5/18 until 23/10/18.

g) The Inspection findings in May 2018 were that, with the level of care seen, any person or persons would be harmed or exposed to the risk of harm. As a result, CQC made the decision to urgently suspend the providers' registration from 9 May to 23 October 2018 using its powers under Section 31 Health and Social Care Act 2008, preventing the registered provider from carrying out regulated activities. Five urgent suspension notices, relating to the five regulated activities for which the practice is registered to provide were issued. This action was taken to protect service users from the risk of harm. The practice did not question the factual accuracy of the report dated 13/8/18 or proceed with an appeal against the suspension of the registration.

h) NHS England (NHSE) put a caretaker practice, the Forest Group Practice, (the FGP) in place to run and manage the location (contracted until 23/10/18). From June 2016 Dr Ali and Dr Agoe worked at the service as locums, seeing patients without any responsibility for the service. The service remained in special measures.

i) A further announced comprehensive inspection on 2/10/18, with a full team of specialist advisers. The practice was found to have not made sufficient improvements to provide safe care and to reduce risks to service users' health, safety and wellbeing. As at 2/10/18, areas of risk included: systems for safeguarding children and vulnerable adults; management of significant events; prescribing and medicines management; the process for managing two-week referrals for patients with suspected cancer; inadequate patient access to the service; ineffective use of clinical audit to drive improvement; poor record-keeping;

an inadequate complaints system; ineffective processes for managing health and safety; a lack of evidence that all staff received appropriate training.

j) On 19/10/18, further suspension notices were served. No appeal has been made against the further suspension.

k) The service commissioners extended the existing caretaking arrangement until 1/11/18. On that day NHS England informed the CQC that the Appellant had refused to allow the caretaker practice to take control at Morum House.

l) Application was made by the CQC to the Magistrate on 6 November 2018. The order was made because it appeared that that there will be serious risk to a person's life, health or well-being unless the order was made.

The Notice of Appeal

8. In section H of the appeal form it was contended that the application to the Magistrate was an abuse of statutory powers that makes a mockery of the rule of law: the partnership was dissolved and no longer extant. The application was made after Drs Agoe and Ali issued a claim in the High Court on 5 November 2018 seeking a declaration on the issue of whether a dissolved partnership survives for the purpose of the CQC registration regime. That claim is still pending.

The Response to the Appeal

9. In summary the Respondent relied on the evidence of Mr Smart and Professor Gallagher which had been presented to the Magistrate. The facts set out in those statements, providing evidence of serious risk to life, health or well-being were not challenged on behalf of the Appellant. The submissions focussed on the status or composition of the partnership. Abuse of process was denied. The Respondent explained the policy regarding applications to vary. The effect of the partnership condition was that whenever a partner left or joined an existing partnership an application under section 19 was required. This enabled the CQC to restrict its assessment to the change, and to grant or refuse based on the impact of that change. Changes in partnership occur regularly. For the Appellant to assert that changes should be regarded as a general dissolution affecting its registration was wrong in law and would be contrary to the CQC's policy. It would result in circumstances where regulated activity would be provided without lawful authority and would adversely affect the CQC's role as regulator and be contrary to public policy. The Appellant's case is without merit.

The Appellant's evidence

10. We set out below the key matters in Dr Agoe's statement dated 3 December 2018:
    i. When she went to work in the practice in 2005 there were seven partners. She became a partner in 2008. By 2013, when compulsory registration with the CQC was introduced, the individuals trading as the Staunton Group Practice were herself, Dr Ali and Drs S and B. Dr S was approved as the Registered Manager.
    ii. Dr Agoe describes the challenges faced by the practice which included recruitment of a new practice manager. In 2016 the practice experienced significant disruption due to the migration of the clinical system from Vision to Emis Web which took a long time to resolve. The practice struggled to keep the daily operations going whilst working on the backlog of accumulated

correspondence post migration. The practice was stretched to the limits and moral and productivity began to suffer. Frictions and conflicts began to emerge amongst staff and partners. The practice needed a radical change to the culture of the organisation and required new strategic thinking. Drs S and B were opposed to the proposed changes and this started to affect the partnership dynamics. The partnership had also to deal with employment grievances.

iii. In 2017 the practice received resilience support under the vulnerable practices pilot scheme. The funds were used by Haringey CCG to commission Primary Care Management Solutions. There were further grievance issues between the practice manager and IT manager. The inspection in July 2017 was at a time of extraordinary difficulty. The dysfunctional dynamics between the partners and the administrative team were laid bare. Actions plan were prepared but there was a difference in views regarding which should be implemented. At the focussed inspection the practice action plan was sufficient for the CQC Warning Notice to be revised to "requires improvement". Other support was enlisted but the difficulties between the partners persisted.

iv. In March 2018 Dr B served notice of intention to leave the partnership and Dr S also intended to leave. In April 2018 NHSE served a remedial notice concerning alleged breaches under that GMS contract.

v. The result of the May 2018 CQC inspection was that the registration was suspended and the practice was not permitted to deliver clinical services. A caretaker practice was brought in immediately to take over the provision of medical services under an APMS contract.

vi. In June 2018 following the intervention of the Local Medical Committee (LMC) Drs Ali and Agoe were allowed to work as part time locums for the caretakers and under the caretaker's registration.

vii. In September 2018 Haringey CCG (clinical commissioning group) convened a meeting attended by NHSE, the LMC and Drs Agoe and Ali. The Haringey Federation wanted to take over the practice and employ Drs Agoe and Ali as salaried doctors. Drs Agoe and Ali rejected this and proposed for NHSE, the CCG and the LMC to meet with them and new prospective partners. The meeting did not materialise.

viii. Drs Agoe and Ali understood on the basis of legal advice that the new partnership would need to make a new application for registration. They worked with the new partners on a remedial plan. However, NHSE were working to take away the GMS contact by terminating the same and appointing the Haringey Federation to take over.

ix. On 4 October 2018 NHSE told the Appellant that it was not prepared to accept the proposal to add the new doctors to the GMS contract. On 13 October NHSE served a Notice of Termination. On 22 October 2018 Drs Agoe and Ali sought and obtained an interim injunction by order of Mrs Justice Andrews, restraining NHS England from terminating the GMS contract. On 9 November the action was resolved by consent on terms.

x. Dr Agoe goes on to state (at para 54, 55) that *"in the meantime the caretaker's contract was coming to an end on 31 October 2018, our solicitors wrote to NHS England and proposed that as the Court had determined that our GMS contract was not to be terminated in any circumstance, it would be expedient for the current caretaker or any new caretaker to be appointed to provide services"* whilst a new registration application to the CQC was considered. NHSE disagreed and proceeded to make arrangements with the Haringey Federation. She and Dr Ali disagreed that they should be appointed as caretaker. They were anxious that

once they moved in their temporary contract would be made permanent and their own GMS contract would eventually be terminated.

xi. An application to the CQC for the new partnership of 5 was made on 26 October 2018. Dr Agoe said *"We had made that application at the time so that on 31 October 2018 when the caretaker's contract ended, we may be able to provide regulated activities to patients under our GMS contract without any threat of being in breach of section 10 of the… Act."* She understood that the CQC may not (in the exercise of discretion) take enforcement action where an application is made and services are being provided pending a decision. Her understanding, on the basis of legal advice, was that the CQC was unlikely to take action against the new 5 partners if they carried out regulated activities whilst the new provider application was processed.

11. It is clear from Dr Agoe's statement that she believes that the CQC took the action it did to assist NHSE. She considers that Mr Smart was there on 1 November to carry out the agenda of NHSE. She complains of abuse of statutory power. Specifically, she alleged in her statement that the Respondent has *"made up safety issues as the basis of its application to cancel where none existed."*

12. Dr Ali provided a statement dated 3 December 2018, adopting that of Dr Agoe.

The Respondent's evidence in response

13. We need not set out the detail save to note that Mr Smart provided a very detailed statement in response to the factual allegations made surrounding the decision under appeal. Further evidence in response to the Appellant's case was also provided by Dr Jowett, Mr Brown and Mr Walton and Professor Gallagher

The Hearing

14. We received and had read, in advance of the hearing, an indexed and paginated bundle which included witness statements on both sides as well as skeleton arguments from both representatives.

15. At the start of the hearing the judge, on behalf of the panel, explained the panel's understanding of the issues in terms of the nature of the appeal so as to enable the parties to make submissions if our intended self-direction was incorrect and in order to ensure that that hearing was conducted fairly and efficiently. In this context the judge explained that:

a) In so far as any past facts in issue the Respondent bears the burden of proving the facts on which it relies. The standard is the balance of probabilities. The ultimate issue involves a risk assessment on the basis of all the material before us, including any findings we may make in relation to past facts. The Respondent bears the burden of satisfying the Tribunal that "it appears that, unless the order is made, there will be a serious risk to a person's life, health or well-being".

b) The panel had noted the Appellant sought various declarations. The judge referred the parties to section 32 (4) of the Act and explained that the panel's task was not that of judicial review. The ultimate task for this panel was to decide as at today's date whether the decision of the Magistrate should be confirmed or set aside.

c) The panel had noted also that the Appellant seeks to rely on partnership law but the Appellant's case in relation to the issue of risk was not entirely clear.

d) We had received rival versions of a Scott Schedule. The Respondent had provided one which identified the issues and the facts it considered relevant. The Appellant had rejected this and prepared a schedule which was relatively brief and addressed the partnership issue only. In a nutshell, it was apparent from the papers before us that the Appellant's position was that the decision of the Magistrate was ultra vires/wrong/unlawful because, it was argued, the partnership did not legally exist when the decision was made (or now). Conversely, the Respondent's schedule had sought to elicit agreement or comment on the issue of risk and the history of the inspections, to which there had been no response by the Appellant within the proffered schedule.

e) The panel had already read the arguments about the versions of the Scott Schedule set out in correspondence. The panel said that was minded, in principle, to direct that the Scott Schedule prepared by the Respondent should be completed as this would assist the panel. We said we would permit time that morning for this to be done in manuscript. The parties agreed with this approach.

13. The judge also raised as a preliminary matter that, on the evidence before us, there appeared to be a conflict of fact regarding a conversation between Dr Jowett and Dr Ogunsanya on 1st November 2018. As Dr Ogunsanya is the advocate instructed to represent the Appellant's case this raised the potential for difficulty and embarrassment. The panel noted that no reliance had been placed on any witness statement from Dr Ogunsanya but it was clear that Dr Agoe was relying on Dr Ogunsanya's account of what Dr Jowett had said to him on 1 November 2018 and, further that this was firmly denied by Dr Jowett. The panel's concern was that, as a matter of principle, it was not appropriate for a panel to be placed in the position of having to resolve a credibility dispute as to past facts between, even indirectly, an advocate and another witness. The panel therefore considered that it was for the Appellant to choose if they wished Dr Ogunsanya to act as advocate or to be a witness.

14. Having taken instructions Dr Ogunsanya said that it had been decided that he would act as advocate. He said that he fully understood the reasons he would not be permitted to rely on his version of the events in either cross examination or submissions. His position was that the issue, in so far as relevant, could be fairly determined on the other evidence available.

15. By agreement we received further material from both sides for which a further amended index has been provided by the Respondent.

16. We allowed time for the completion of the Scott Schedule which was duly provided. In response to the issues identified by the Respondent the Appellant contended, that :
    A. There was no serious risk to a person's life, health or well-being.
    B. The issue of a *"technical dissolution is a legal nonsense in the context of an application before the Magistrates Court"*
    C. The HSCA (Health and Social Care Act) does not have its own partnership law. The Tribunal is required to make a finding as to the Respondent's policy.
    D. It is trite law that a partnership is not a legal entity and the departure of a partner creates a new partnership. As to accrued rights and liabilities that is governed by the Partnership Act.

E. *"The Appellants were not registered pursuant to the Respondent's own policy (re dissolved partnerships)."*
F. The Magistrates cannot exercise jurisdiction over an entity or registration that no longer existed.

17. The facts alleged in the Scott Schedule (1-21) were agreed without qualification save as follows:
    - As to para 5, the Appellant's case is that the rating of inadequate in October 2017 was partly due to a change in the computer system.
    - As to para 16 (the inspection on 2 October 2018), it was not agreed that *"the service was found to have not made sufficient improvements to provide safe care and to reduce risks to service users' health safety and well-being."*
    - As to para 20 (1 November 2018) the Respondent's case is that Dr Agoe had refused to allow the caretaker practice to take control of the practice and had instructed the practice manager to email practice staff to inform them that it was "*business as usual."* The Appellant's position is that this is "*incorrect and disputed, A clear attempt to undermine the order of Mrs Justice Andrews prohibiting the termination of the GMS contract."*
    - As to para 21, (1 November 2018) a qualification was made that patients were seen by Drs Agoe and Ali as locums.

18. Before oral evidence began the judge made clear that the statements of the witnesses would stand as their evidence in chief, subject to any necessary clarification or supplemental questions. The judge also explained to the parties that any disputed facts or matters within the statements on which the parties intended to ultimately rely were to be put in cross examination.

19. We heard oral evidence from the following witnesses:

    For the Respondent:
    Mr Andy Brown, CQC Registration Advisor
    Dr Sally Jowett, GP Partner, Forest Road Group Practice (FGP)
    Mr Alistair Walton, CQC Interim Registration Manager
    Mr Ian Smart, CQC Inspector
    Professor Ursula Gallagher, CQC Deputy Chief Inspector.

    For the Appellant:
    Dr Belinda Agoe, GP Partner, The Staunton Group Practice.

20. All the witnesses adopted their statements as evidence in chief, answered questions in cross examination by the representatives and also responded to the panel's questions. We will not set out the oral evidence but will refer to key aspects hereafter.

21. Before Dr Ogunsanya closed his clients' case, the judge asked whether he wished to tender Dr Ali for cross examination. He took instructions and said that Dr Ali relied on Dr Agoe's evidence (which position was entirely consistent with his statement). The hearing was adjourned at 12.25pm for submissions to commence at 1.30pm.

22. When the hearing resumed for submissions at 1.30pm Dr Ogunsanya made an application for the evidence to be re-opened because Dr Ali had decided that he now wanted to give

evidence to clarify some aspects of Dr Agoe's evidence. When asked what his evidence would cover Dr Ogunsanya said that it concerned 1 November but was otherwise non-specific. Mr Dos Santos objected to the application, not least because it imperilled the time table and might involve the need to recall witnesses.

23. Despite the judge's inquiry of Dr Ogunsanya, it was not entirely clear to us to what issue (s) the further potential evidence of Dr Ali would be directed. We decided that the fairest course was that we would permit a short period in order that Dr Ali could provide a witness statement setting out the evidence he wanted to give, which we would then consider. The short witness statement thereafter provided explained why Dr Ali now wished to give evidence. It referred to his having wanted written reassurances from NHSE in the light of his experience on 9 May. It became clear that the statement did not actually set out the additional factual evidence he would, or might, give.

24. We heard representations and considered the overriding objective and paragraph 15 of the Rules. We refused the application. We reserved our reasoning given the constraints of time. This appeal had been carefully case managed prior to the hearing. The parties were well aware that they had to serve the evidence on which they relied within a given time scale. Dr Ali had chosen to provide a statement that effectively endorsed Dr Agoe's statement. Although given the opportunity (even beyond the 11th hour) to set out precisely what he wanted to say**,** his additional statement was in broad terms. It was not clear to us what this added to his earlier statement endorsing Dr Agoe's statement or how this would assist in deciding the key issues fairly and justly. We considered that if he were permitted to give evidence (when the Respondent had no notice of precisely what he might say) this would inevitably absorb time which would imperil the conclusion of the evidence and submissions that day, so causing a probable adjournment with all the difficulties involved in reconvening a part heard case. It is simply not enough to say that it is in "the interests of justice" that further evidence is heard.

25. Before oral submissions began the judge made it clear to the representatives that if reliance was placed on any particular authority or evidential point regarding the law then the panel should be directed to the particular passages within the bundle.

The Respondent's Submissions

26. We summarise below the main points made by Mr Dos Santos. On the issue of risk there was a plethora of evidence. The clear focus of the inspection on 2 October was whether the remedial steps taken were embedded and will last. IS9 sets out clearly why the concerns remained. Was there an ongoing risk without a CTP in place? Did the care taking relationship come to an end? If the Appellant had engaged with the issues there would have been a wealth of opportunity to set out a point by point refutation. However, the panel will struggle to find anything regarding the factual dispute regarding 1 November. No weight should be attached to D428. It beggars belief to suggest that FRP was in place as the caretaker practice on 1 November or any time thereafter. It was clear from Dr Agoe's statement that her understanding was that the CQC would not take enforcement action pending consideration of the partnership application. It was clear that she was unable to recognise the need for a caretaker practice. There were a number of red herrings such as issues about the NHS contracts and challenges now made about the inspections, none of which touch upon the issues that the panel has to resolve.

27. Mr Dos Santos then made submissions regarding the point taken regarding partnership law and referred us in detail to **Maillie v Swanney** (OH) [2000] SLT 464 and the text in the

fifth edition of "Partnership Law" by Blackett-Ord and Haren. This was not a real and genuine issue. The CQC regulate the provision of services and the overriding issue is patent safety. Mr Brown's evidence was dispositive regarding the practical consequences of treating each application to vary or amend as the ending of the registration of an existing and registered service provider. The Respondent has a published policy. No one doubted on 1 November 2018 that the Staunton Group Practice was a regulated service provider. The real issue is: was there a registration that could be cancelled?

28. As to Dr Agoe's evidence, there were irreconcilable differences between her account and that of the respondent's witnesses. It was clear that the partners refused to allow Federation4Health to take over. There was no escape from her statement which made clear Dr Agoe had other intentions for the practice. It was always known there would be a follow up inspection to assess progress in October. There had been nothing to stop Drs Agoe and Ali being able to demonstrate their understanding.

The Appellant's submissions

29. Since the Appellant's case as presented before us has evolved in some respects, it is appropriate to set out the vast majority of the submissions made. Dr Ogunsanya submitted that:

    a) The key word was "serious". No doubt there were safety issues. Dr Agoe accepts that there was risk. The doctors could not walk away but decided to stay and tackle it. The suspension in May 2018 made it difficult to do the work that needed to be done. It was admitted by Dr Agoe that work needed to be done. In May 2018 they were working with the care taker to deal with some of the issues. There were difficulties with the NHSE intervention and decisions as to what the doctors could or could not do. It was this frustration that led Dr B to leave after the May inspection. On 2 October 2018 the partners were still in the same position. Although working with the caretaker practice not all problems were being identified. The CQC agree there has been remarkable progress but there were still some issues. To say that Dr Agoe lacked insight is not correct. The partners could not have done anything until the LMC intervention.

    b) If on 2 October 2018 the CQC could see serious risk then they should not have been suspending the practice. It followed that the CQC did not consider the risk was serious on 2 October because the suspension was extended (i.e. as opposed to a notice of proposal to cancel).

    c) The partners were the landlord and had control of the building. They could have prevented them coming in. The partners came in to do clinical work as locums. This was not a partnership shying away from its responsibilities. If NHSE wanted to change the GMS contract they should have given adequate notice. What they did was to serve notice of termination. The High Court were aware of the CQC but felt that NHSE needed restraint. There was no attitude by the partners to stop Federation4Health. They allowed them to come in. The evidence is that the partners wanted to seek clarity. The partners were still the data controllers. If there was to be a change in the caretaker arrangement NHSE should have told them. It was completely wrong for a statutory body like NHSE not to have given notice. There was a lack of clarity and ambiguity which is why Dr Agoe had discussions with Dr Jowett who said they would support the partners until there was clarity, and regardless of whether they were being paid or not. It was not accepted that there were any obstacles from the partners to Federation4health coming in. The CQC

were *"hoodwinked"* by NHSE because NHSE solicitors contacted the CQC. The CQC did not make inquiries of its own as to why Federation4health was not allowed in so as to be in charge of the service.

d) The CQC had *"rushed to judgement".* Drs Agoe and Ali should have been asked what was going on. Drs Agoe and Ali were seeing patients as locums. Mr Smart did not clarify with them what they were doing in terms of their registration. He (Dr Ogunsanya) had asked Dr Jowett in cross examination who arranged the locums and she said that she was expecting the new caretaker to take over. Dr Ogunsanya submitted that arrangements for locum contracts are not made on the same day. Drs Agoe and Ali did not consider themselves in charge of the practice.

e) The Respondent bears the burden of proof. There was no evidence to show Drs Agoe and Ali gave orders to the practice manager. Dr Jowett was there and they (the FGP) was still running the practice. At the MDT meeting on 6 November Dr Stork took the lead. They were not handing over because there was still a lack of clarity about Federation4Health. Looking at the matter today *"if Federation4health had been done the week before we would not be here."*

f) Professor Gallagher had said that she expected the partners to close down the service. It was not in the interests of patients that Dr Agoe could not work. It was not accepted that Drs Agoe and Ali should not have been there.

g) The judge reminded Dr Ogunsanya that Professor Gallagher's evidence had referred to two options open to the Appellant i.e. closure of the practice or allowing Federation4Health to take control. He replied that Doctors Agoe and Ali had control of the property. They allowed Federation4health in. They were anxious that Federation4health had come to take over. It would be extraordinary if they had not been anxious. If, because of anxiety, they refused it was understandable. He was not saying that the reason Federation4health were not allowed to caretake was because of the termination of the contract with the FRG (as caretaker). It could have been done in a clearer way by giving appropriate notice. The partners should have been given notice.

h) As to the issue of risk Dr Agoe accepted there was some risk. She had also said there were some factual inaccuracies in the inspection reports. Mr Smart had not referred to this in his witness statement or evidence and this went to his credibility.

i) The judge reminded Mr Ogunsanya that Dr Agoe's witness statement had not set out some the matters on which she now relies. He accepted that Dr Agoe's witness statement had not dealt with some of the issues for which he apologised. It was because the primary ground was just a matter of law (about partnership law).

j) If it was said today that Dr Agoe had no insight that would be clearly wrong. She has been at that practice for 17 years. She has said how ashamed she has been that the practice was the only one in the Haringey group with different software and she had taken steps to deal with this. There was no doubt that the partnership was dysfunctional and errors had been made in the partnership. Dr Agoe wanted to make a new beginning. There was no serious risk on 1 November. When asked what had changed between 2 October and 1 November, Mr Smart had said that his concern was the risk of harm to patients. The concern was that there was no caretaker in place but the doctors were already making arrangements to improve things. Dr Ogunsanya submitted that he did not see how the practice could improve

with only two partners. There had been no proper thought by NHSE as to what needed to be put in place.

k) Serious work has been undertaken re the two-week cancer referral. It was not that the work was not being done, but simply that the old protocol was brought up on the system for the CQC on 2 October. This was an administrative error on the day. This did not show a lack of understanding on Dr Agoe's part. Measures were being taken regarding the telephone system. Work was being done within the confines and limitations of the suspension. Dr Agoe has spoken about how she dealt with significant events but on the day of inspection it was not possible to populate the evidence to show to the CQC. Dr Agoe was the Safeguarding Lead and she had made sure that every person had the Safeguarding Protocol about how to report issues of concern. Regarding c113 para 6 – this concerned a safeguarding alert for a one-year old child that Dr Agoe had explained to the panel. The FGP was in charge. It was not the case that Dr Agoe was in charge and able to deal with that problem.

l) At the inspection on 2 October no proper questions were asked. The FGP did not take an active part in the inspection. There was no evidence that the CQC looked at the effective or added value of the FGP. There was no inspection of the caretakers themselves. If anything was wrong, it was ascribed to the partners whose hands were tied. Dr Agoe understands the policy and can put the policy into effect but it was something she could not do because of the restraints (i.e. of suspension) upon her. Dr Ogunsanya posed the question: why are NHS resources being spent on a caretaker when problems have not been rectified?

m) The panel had heard evidence from Dr Jowett of the problems that arise regarding prescriptions. So the caretaker was just as ineffective as the suspended provider. All the problems found in May were still not being dealt with in October. Drs Agoes and Ali were not in charge. It was unfair and unjust to hold them to account for failings not being dealt when the partners were just locums. He took the point that Dr Agoe and Ali could deal with process improvements but that was not what NHSE wanted. The NHSE were paying *"loads of money".* He accepted that process issues can be dealt with behind the scenes but submitted that the only thing that can be shown is what the process is and whether it was understood. The doctors were not in charge. It was not fair, just and equitable because the partners were not able to do the work because of the activities and behaviour of NHSE.

n) Drs Agoe and Ali had engaged with the medication reviews which was work being done by the caretaker. They did not object to working with the caretakers. How could it be said that they did not have insight? They could have walked away. Dr Agoe had wanted to show that they did it. At the end of the day the doctors had done their best in the circumstances. Dr Agoe did not bury her head in the sand. What else could she have done to demonstrate that she has insight and wants to improve patient care? The risks were not serious enough to warrant urgent cancellation.

o) Dr Ogunsanya then set out the Appellant's position regarding the sequence of events regarding the urgent application to the Magistrate. He said that an application has been made before Mr Justice Warby on 5 November 2018 to seek to restrain a cancellation order being made by CQC the next day. The discussions between the lawyers were to try and persuade the CQC not to make an urgent

application because there was a pending claim in the High Court. Mr Ojo had attended the urgent application before the Magistrate on 6 November.

30. Having completed his submissions on the issue of serious risk Dr Ogunsanya made his submissions regarding partnership law.

    a) It is trite law that when 2 or more persons are in business for profit this is a partnership. His position was that it was a condition of registration that there were named partners. The CQC position now was inconsistent.

    b) The partnership had become one of three - see D97 and 102. Mr Dos Santos was correct that this was a technical dissolution because the partners carried on the business. There was no real argument on this. It did not take the matter any further forward to argue if this was a technical or general dissolution. He (Dr Ogunsanya) would say it was a dissolution. His core position was that it cannot be correct that registration (of four named partners) continues for the purpose of regulation.

    c) Dr Ogunsanya made the point this created problems for Dr B. The partnership made an application to vary the conditions of registration and the CQC should have varied the registration but this had not happened. The intention was to inspect in May so the application was kept on hold. No one could point to a CQC policy that deals with this situation. By maintaining the registration the CQC can do whatever it wants, but when the CQC inspected in October Dr B was not there. This was an interference with the Article 8 rights of Dr B. It meant that Dr S was also trapped with the problem of the practice. He asserted that nobody had given Dr S notice or information. He considered he was entitled to make these submissions, even though he is not instructed by Drs B and S, because he is an officer of the court and a guardian of the rule of law. The CQC position cannot be correct. This was a gross abuse of regulatory power and amounted to an Article 8 interference. Criminal sanctions attach to regulation. A professional should not be placed in this position.

    d) The judge asked Dr Ogunsanya to address the authorities on which Mr Dos Santos relied regarding the partnership issue. He submitted that **Maillie v Swanney** was a Scottish case so was not applicable. The only point made in Blackett-Ord is that regarding technical and general dissolution.

    e) The judge asked Dr Ogunsanya to address the following: if taken to its logical conclusion, his argument appeared to be that if a partnership at will decided to "dissolve" at will, then the CQC could not take any regulatory action at all regarding the registration of the service provider. He said that this was not his position. If registered with the CQC then the partnership was still liable to sanctions. He agreed that "dissolution" did not exclude regulatory action. His point was that the cancellation should have been made with the correct partners: in this case Drs Agoe and Ali. He then made the point that there had been no registered manager in place which was a breach. He agreed that the effect of section 19 of the Act was to prevent an application in certain circumstances.

The Legal Framework

31. The Respondent's main objective as prescribed by statute is to protect and promote the health, safety and welfare of people who use health and social care services - section 3(1) of the 2008 Act. The Respondent must have regard to the need to protect and promote the rights of people who use health and social care services - see section 4(1(d)). The CQC must also ensure that action by them in relation to health and social care services is

proportionate to the risks against which it would afford safeguards and is targeted only where it is needed - see section 4(1)(e).

32. A range of measures that are available to the Respondent in seeking to discharge its functions under the Act. This appeal concerns the use of the urgent procedure for cancellation under section 30. This provides as follows:

"(1) If—
(a) the Commission applies to a justice of the peace for an order cancelling the registration of a person as a service provider or manager in respect of a regulated activity, and
(b) it appears to the justice that, ***unless the order is made, there will be a serious risk to a person's life, health or well-being, the justice may make the order,*** *and the cancellation has effect from the time when the order is made.*
(our ***bold****)*

33. An appeal against a decision of a Justice of the Peace under section 30 is made pursuant to section 32(1)(b) of the 2008 Act. On consideration of the appeal the First-tier Tribunal may confirm the decision or direct that it is not to have effect (section 32(4) HSCA 2008).

34. The Tribunal Procedure (First-Tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 provide that:

15 (2) The Tribunal may—

(a) admit evidence whether or not—

(i) the evidence would be admissible in a civil trial in England and Wales; or

(ii) the evidence was available to a previous decision maker; or

(b) exclude evidence that would otherwise be admissible where—

(i) the evidence was otherwise provided in a manner that did not comply with a direction or a practice direction; or

(ii) it would otherwise be unfair to admit the evidence.

The Burden and Standard of Proof

35. In so far as any past facts in issue the Respondent bears the burden of proof and the standard is the balance of probabilities.

36. As we explained at the outset of the hearing, the ultimate issue involves a judgement as to the level and significance of risk on the basis of all the material before us, including any findings we may make in relation to past facts. In an urgent cancellation case, the Respondent bears the burden of satisfying the Tribunal that "it appears that, unless the order is made, there will be a serious risk to a person's life, health or well-being". The threshold test for urgent cancellation is clear and needs no amplification or gloss. For the avoidance of any doubt we do not consider that being satisfied as to the threshold test involves waiting for actual harm to occur. The issue is that of *serious risk* to life, health or well-being, unless an urgent cancellation order is made.

Our Consideration and Findings of Fact

37. It is common ground that we are required to determine the matter de novo and make our own decision on the evidence as at today's date. This can include new information or material that was not available to the Magistrate. It is, for example, open to any appellant

in any given case to rely on evidence to show that the facts on which the Respondent's assessment was based were wrong and/or that the issues have since been addressed. Here, the Appellant's reason for the appeal was that there was no partnership in existence so a cancellation order should not have been made. It is notable that the original grounds of appeal and even the amended grounds of appeal did not refer to the issue of risk. We noted that it was asserted in the Appellant's skeleton that no evidence of risk of harm was served. We find that the evidence before the Magistrate, which included the inspections reports, was comprehensive. Further, in their witness statements, Drs Agoe and Ali did not take the opportunity to challenge the past findings made in the inspection reports, or otherwise address the issue of risk in any meaningful way.

38. In the course of her evidence Dr Agoe raised a number of factual matters about the events of 1 November which had not been set out in her statement and which had not even been put in cross examination. She told us that she had not been advised that she should set out the detail of her case regarding specific factual issues in her witness statement. In the particular circumstances of this appeal, we exercised a great deal of latitude in order to provide Dr Agoe with an appropriate opportunity to explain her position.

39. The redetermination in this appeal includes consideration of the more detailed evidence provided by both sides pursuant to directions as well as the oral evidence which has now been subjected to cross examination over three days. We will not set out the oral evidence but will refer to parts of it when giving our reasons. We have considered all the evidence and submissions before us. We focus on the main points that underpin our decision. It should not be assumed that if we do not refer to any particular aspect of the evidence it has not been carefully considered.

40. It is important to recognise that an urgent cancellation order lies at the very top of the hierarchy of possible enforcement action that can be taken under the Health and Social Care Act 2008. An *urgent* cancellation order can only be made if it appears that *serious* risk of harm to life, health or well-being exists. If it appears that *serious* risk is not engaged the decision should be set aside.

41. If we are satisfied as to the issue of serious risk, the overarching question regarding the exercise of discretion involves making a balanced judgment on a number of matters. In our view this includes consideration of whether the risks can realistically be mitigated by other less draconian measures. This also involves consideration of: the circumstances underpinning any facts that we have found proved: the response of Doctors Agoe and Ali to the concerns raised by the CQC; and their ability and capacity to effect improvement within the time frame involved in possible lesser enforcement measures. Part of the assessment includes consideration of their insight and understanding in the context of the nature and scale of the issues of concern, and their insight into their individual abilities to lead and manage, and to effect and sustain improvement.

42. Before evaluating the issue of risk, we make findings in relation to the factual circumstances that led to the impugned decision. We find that the basic facts are as set out in paragraph 7 above. Additionally, we find that the application to register a new partnership was made on 26 October 2018 and was resubmitted (because of error) on 26 November 2018. We will make further findings relevant to the points placed in issue in the Scott Schedule, and in the oral evidence, hereafter.

43. As set out above our consideration of the issues is made at today's date. It is always open to any appellant to adduce evidence to demonstrate that the service they would provide

today will not present serious risk to the life, health or well-being of patients. The background facts are that there was no appeal against either the CQC decisions on 8 May 2018 to impose immediate suspension on the service provider, or against the decisions on 19 October 2018 to extend that suspension until 24 April 2019. Given that the registration of this practice was (as a matter of fact) suspended, this meant that regulated activities could only be lawfully carried on if an appropriate caretaker was in place.

44. We heard a great deal of evidence about Dr Agoe's wish to be given a chance to tackle the issues at the practice and also about her issues with NHSE. Dr Agoe referred to an action plan devised by the remaining partners and the proposed new partners but the plan was not adduced in evidence. In our view it is obvious from Dr Jowett's evidence that, despite the extensive support provided by the FGP since May 2018, there remained significant fragility in the ongoing delivery of safe care. She was very clear in her evidence that as at 1 November it was necessary for a caretaker to remain in place in order to protect the safety of patients. Her evidence was all the more compelling because she was plainly very sympathetic to the difficulties faced by Drs Agoe and Ali in all the circumstances.

45. We listened carefully to Dr Agoe's evidence. In our view she showed in her evidence that she was unable to acknowledge the depth of the CQC's concerns or those of Dr Jowett. We were left with the clear view that she does not have a full understanding of the breadth and extent of the issues that will require effective leadership and management in the interests of patient safety. In our view this chimes with the evidence of Mr Smart regarding the inspection on 2 October. It is important to recognise that Mr Smart and the specialist advisors were not inspecting the FGP. As shown by the report the focus was on assessing whether Drs Agoe and Ali were able to build on the changes effected during the caretaker regime and to carry forward, and build on, the changes that had been introduced to protect patient safety. The inspection team had concerns in the following areas: safeguarding; significant events; medication review not undertaken/lack of detail; two-week wait cancer referrals; patient access; audit; record keeping; complaints; safety records; training. In particular, the CQC considered that the new systems re safeguarding, significant events and two-week cancer referrals, largely effected by the FGP, were not sufficiently understood by the partners and/or sufficiently embedded. It was considered that this placed patients at significant risk in relation to medication reviews and two-week cancer referrals.

46. The conclusion reached by the CQC was that it was necessary to extend the suspension to protect patient safety. The decision to impose a further period of suspension was made in the knowledge that a caretaker practice would be in place so as to mitigate the risks. We accept that the CQC had no role so far as the choice of caretaker practice because this is a matter for NHSE.

47. Dr Agoe was repeatedly asked by Mr Dos Santos if she accepted that in October 2018 that there was still a need for a caretaker practice to be in place. She did not answer the question but said that she had spoken with Dr Jowett and Dr Stork to discuss how to demonstrate that they (the partners) were taking a leading role. She said Dr Jowett's view was that three more months was required. When the question was again repeated she said she agreed that they (the practice and the FGP) were working together towards a common goal. Asked again if, as a matter of safeguarding patient safety, she recognised the need for a caretaker practice to continue she said that it was difficult to say yes or no "*because of the constraints around what they (the partners) could or could not demonstrate to the CQC."* At this stage the judge intervened to ask Dr Agoe to put aside her point about constraints and other difficulties and repeated the question, stressing that it was about the

objective need for a caretaker practice in the interests of patient safety. She said that there was a need to demonstrate what they (the partners) had done: *"there had to be better terms of reference and guidance so that we could say we have done this."*

48. In our view Dr Agoe was reluctant to answer this key question because acceptance that a care taker was still required illuminated the issue of serious risk. In our view Dr Agoe's reliance on the issue of clear terms of reference was a means of avoiding the issue. The fact is that if a service at Morum House was to continue, the suspension of the registered service provider (and the extension) necessitated that a caretaker practice was in place. The service could not operate lawfully otherwise. We find that the FGP caretaker contract, having been briefly extended, came to an end on 31 October 2018. We accept Dr Jowett's evidence that she attended thereafter, on a voluntary basis, in order to assist in the handover to a new caretaker practice - Federation4Health. She anticipated that handover would be effected on 1 November, going into 2 November and beyond as necessary.

49. Mr Ogunsanya submitted that the fact that the CQC extended the suspension on 19 October 2018 indicated that they did not then consider that there was serious risk. We agree that the threshold test for urgent suspension under section 31 is lower than that required for urgent cancellation under section 30. We do not consider that there is any inconsistency. in our view the level of risk has to be assessed in the context of the hierarchy of enforcement action and the steps that can be taken in the "here and now" to mitigate risk. That is the exercise of proportionality which is set out in the Act – see section 4(1)(e). A caretaker, appointed by NHSE, (if able to take control), would significantly reduce or mitigate the level of risk to patients so affecting the proportionality balance. The situation faced by the CQC in November 2018 was that a caretaker was not in place.

50. Mr Ogunsanya submitted that nothing had changed between 2 October 2018 (when the CQC were content to continue suspension) and 6 November 2018. We disagree. The level of risk as at 2 October was mitigated by the fact the service could only be provided by a caretaker practice. On 31 October the contract with the FGP ended. A new caretaker was to be put in place supervising the practice. It shone through the statement of Dr Agoe that she (and Dr Ali) did not want the Haringey federation, (Federation4Health), to be the new care taker because they had refused support in the past, and had already made overtures regarding a takeover. We find that Drs Agoe and Ali disagreed with this and wanted to present their own plan to carry on with a new partnership. However, they had lost sight of the fact that the registration was at all times one that was suspended. They could not lawfully be in charge. If the service was to continue when the registration remained suspended, and if Drs Agoe and Ali were to work in a locum capacity, it had to be under a caretaker arrangement.

51. We accept the evidence of Dr Jowett that the situation on 1 November and thereafter was extraordinary. She told us (and we accept) that originally the staff attending from Federation4Health for the handover by the FGP were left outside in the rain. She managed to secure agreement for them to enter the building but they and staff from NHSE were confined to one part of the building away from the clinical hub. The effect of her evidence was that there was a refusal to handover. She tried to facilitate but to no avail. She said that the situation was one of chaos and no one was in control of clinical leadership. In our view it was simply not tenable for the CQC to fail to seek urgent cancellation in the public interest given the serious risk to life, health and well-being engaged. The picture she described was effectively that of a stand-off between two camps. The staff of Federation4Health and NHSE attended the practice and were waiting in the wings each working day until the matter was resolved by the order made by the Magistrate.

52. We noted that Dr Agoe said in her oral evidence that she was unaware that there was to be a handover to Federation4Health until 1 November. This assertion only emerged in the course of cross examination. In our view this is inconsistent with her witness statement which makes clear that she knew that the FGP contract was coming to an end and the intention of the CCG and NHSE was that Federation4Health (the Haringey Federation) would take over as caretaker.

53. Amongst other matters Mr Smart's evidence is that the practice manager told him when he arrived on 1 November that the staff had been told by the partners, that it was *"business as usual".*

54. It is unnecessary to deal with the entirety of what happened when Mr Smart attended the practice on 1 November because the allegations of bad faith, abuse of process and conspiracy were not pursued in cross-examination. One part deserves attention. We find that when asked by Mr Smart on 1 November if she had been working that day Dr Agoe wanted to, and did speak, to her solicitor before answering. We accept Mr Smart's evidence, which is supported by the record he made that day, was that he heard the solicitor tell Dr Agoe to *"say yes on my advice."* We accept Mr Smart's evidence that he told Dr Agoe that seeing patients and carrying out regulated activities was in breach of the suspension and was also an offence under section 34 of the Act. We accept that Mr Smart urged Dr Agoe and Dr Ali to consider their actions and said that acting on legal advice was not a viable defence to prosecution. He urged them to cooperate with the NHSE and the new caretaker. Dr Ali told Mr Smart that he had no issues with him or the CQC throughout his dealings with the practice and that the problems were with NHSE.

55. We find that Dr Agoe and Dr Ali were prepared to continue to work despite having being advised by Mr Smart that this was in breach of the suspension, and they would be committing an offence. It is surprising that a professional person would act in this manner. It suggests a very poor understanding of the importance of compliance with regulation. Dr Agoe's explanation to Mr Smart on 6 November was that she believed that she was able to continue to work because she was covered by the FGP caretaker arrangements. Her case is that she understood this had been confirmed to Dr Ogunsanya over the telephone. We do not, however, accept that Dr Jowett told Dr Ogunsanya that Dr Agoe was able to continue to work under the Forest Group caretaker arrangement. That contract had ended, and had ended at the wish of the FGP.

56. The Appellant relies on a very brief letter dated 17 January 2019 from Ms Idusogie, the practice manager, which states that she was present on 2 November when Dr Stork said that the FGP registration was covering the practice. The document was produced only at, or shortly before, the day of the hearing and is not backed by a statement of truth. There was no application to be allowed to call Ms Idusogie. We attach no weight to the letter.

57. We considered the potential for misunderstanding on the part of Dr Agoe given that Dr Jowett had said to her that she and Dr Stork would do what was necessary to facilitate the handover. In our view the overall impact of all the evidence, not least Dr Agoe's written statement, is that she knew in late October that the FGP contact was to end and a new caretaker would come in. The reality is Dr Agoe did not want Federation4Health to take over and somehow thought that this justified her stance. Her stance is, however, extremely difficult to understand because the suspension was in force: in the absence of a caretaker the service could not lawfully operate at all. This plain fact is one that she and Dr Ali have not acknowledged.

58. The fact is that what we have described as the stand-off with Federation4 health and NHSE waiting for the handover persisted throughout 1 and 2 November and on 5 and 6 November.

59. Dr Agoe told us that she was not even aware that an application to cancel registration was to be made to the Magistrates Court on 6 November. This is odd given that she was aware that an application was made on her behalf in the High Court to seek an injunction against the CQC restraining any enforcement action. It appears from the Statement of Case provided to the Magistrate that notice had been given. Further, Mr Ojo appeared on her behalf at the hearing at the Magistrates Court (where he also cross-examined Mr Smart). If what Dr Agoe is saying is reliable he did so without her knowledge or instructions. This seems very improbable.

60. In his second statement Mr Smart gave (amongst other matters) a detailed account about what happened on 7 November. The unchallenged evidence of Mr Smart was that in the afternoon of 7 November 2018, he along with his manager, Andrew Norfolk, went to the practice where they were joined by Vanessa Piper of NHSE. Ms Idusogie, the practice manager, informed him that Dr Agoe had again told staff it was business as usual, but had not made any reference to either caretaker. Ms Idusogie did not know whether Dr Agoe would be returning to the practice that afternoon. Dr Ali had a list commencing at 3.30 pm. They asked Ms Idusogie for a copy of the appointments list for the day, which she provided shortly afterwards. Two salaried GPs, as well as one locum, had been operating during the morning, together with six nurses, Staff from Federated4Health were still waiting for the handover to take place, having attended each surgery day since 1 November. Dr Agoe had offered them log in identification details for the clinical systems that morning, but these had been declined as Ms Piper had not been present to oversee the process at that time. At 3.30 pm they went to see Dr All, but his consulting room was empty, Ms Idusogie told them she did not know Dr All's whereabouts. After several attempts,' she managed to get through to Dr Agoe's mobile. Over the speaker, Mr Norfolk asked whether Dr Agoe had received the cancellation notice served the previous 'evening. She confirmed she had. Mr Norfolk asked if she accepted that the registration was cancelled. She confirmed she did. Mr Norfolk asked if the practice would now agree to the handover of the caretaking. She confirmed she would and stated that she had offered the Federated4Health staff the log in details that morning.

61. Dr Agoe effectively said in oral evidence that she did not do anything to impede the new caretaker arrangement. We find that she did not provide the codes to enable access to the clinical system until after the order had been made by the Magistrate. This speaks volumes. When assessing the evidence in the round we bore fully in mind that Dr Agoe's family circumstances were very difficult at about this time which might provide an explanation for the many inconsistencies in her account, and even her attitude. We are, however, unable to accept that most aspects of the factual account that Dr Agoe gave in her oral evidence are reliable. In so far as there is any conflict as to the facts, we prefer the evidence of Dr Jowett and Mr Smart.

62. Much complaint has been made about NHSE but we are not concerned with the rights and wrongs of that dispute. Our focus is the level of risk as at today's date.

63. What is the position now? Despite the opportunities provided in an appeal that considers the present situation, no substantive evidence has been presented to show that the Appellant, with new potential partners, are now able to carry on the practice without serious risk to the health, safety and well-being of patients. It was unclear to us what Dr Agoe envisages would happen if this appeal were to succeed. It is apparent from her statement, and also from the fact that she and Dr Ali sought an injunction in the High Court restraining enforcement action by the CQC, that it was somehow hoped that they would resume

control and the Respondent, (who, had the application for the injunction succeeded, would have been unable to take any enforcement action), would approve the application for a new partnership with three new doctors despite the suspension. In our view the attitude shown on 1 November demonstrated that Dr Agoe was unable to acknowledge that the registration of the practice remained suspended and that the service could only operate under a caretaker practice.

64. We considered the evidence in the round. We remind ourselves of the long history of sustained and significant issues at the practice which underpin the issue of risk. The rating in 2017 was "inadequate" save for 'are services caring?' for which the judgement was 'requires improvement'. Significant concerns relating to Safe care and treatment and Good governance were identified. The practice was placed in special measures as from October 2017 and warning notices under regulations 12 and 17 were issued. We recognise all the challenges and difficulties faced by the practice as set out in Dr Agoe's statement.

65. In our view findings of the inspection in May 2018 were very serious: the practice was inadequate in all domains. The range of inadequacies covered basic areas in the safe delivery of clinical care where timely and efficient care is needed to protect the life, health and well-being of patients. We find that the clinical oversight required to ensure patient safety undertaken by the FGP was extensive and intense. Although the FGP had promoted the quality of service we are satisfied that serious risk remained. We reject the argument that any risk issues were attributable to the FGP.

66. We accept Mr Smart's evidence that at the planned inspection on 2 October Drs Agoe and Ali were unable to demonstrate their understanding of some of the changes put into place. Overall the inspection report regarding 2 October provided cogent evidence that demonstrated that the improvements that had been put in place under the influence of the FGP were not yet embedded.

67. We consider that Professor Gallagher's evidence was clear, consistent and cogent. Far from being a "rush to judgement" as claimed, we are satisfied that the CQC has, at all times, acted in a rational and reasonable manner. We find that the reality is that Drs Agoe and Ali should either have closed the practice on 1 November or allowed the new caretaker in to take on the role of clinical governance moving forward. The effect of the decision made by Drs Agoe and Ali was to ignore the suspension, and not to allow the new caretaker practice to provide the clinical governance that was so very obviously required in the interests of patient safety. In our view it is obvious that the threshold test that "there will be a serious risk to a person's life, health or well-being" was met.

68. The Respondent has satisfied us that the high threshold required for urgent cancellation in section 30 was met. It is still met today because the evidence adduced before us does not show any material change.

69. We have considered the arguments advanced in relation to partnership law. We consider that the Appellant's argument is misconceived on a number of levels. In our view the issue as posed by the Respondent is the correct one: was there a registration in existence to be cancelled?

70. We find that the evidence of Mr Brown regarding process and policy was clear, cogent and reliable. Mr Brown is the CQC's national Registration Advisor. His evidence explained the history of the registration policy, which is a published document, and the development of registration practice. He was a very impressive witness. There was no effective challenge to his evidence.

71. We consider that the Respondent's published policy is entirely in line with what one would expect in a regulatory context. Section 19 makes clear that the registered provider is able to apply to vary a condition so as to remove or add a partner or to cancel registration. As one would expect, there are exceptions which prevent an application being made whilst certain regulatory decisions are pending. The point of that is obvious. It is contrary to the public interest in efficient regulation that those who may be subject to a pending (possibly) adverse decision can simply remove themselves as registered providers so as to avoid regulatory decisions. We recognise that no one suggests that any of the section 19 exceptions applied when the applications were made. In our view the existence of section 19 supports that the key point is that a registration continues until a decision is made by the regulator, (whether in response to an application by the practice to vary or cancel, or as is considered necessary in the exercise of enforcement action.) The continued existence of a registration is not, in our view, dependent upon partnership law. The key is the existence of registration. Dr Ogunsanya effectively conceded this point preferring, in the final analysis, to argue a very narrow point about the effect of cancellation on doctors who have associated themselves with the appeal before us.

72. Mr Walton gave factual evidence as to the applications made and how they were dealt with. We consider that he was a reliable witness and we accept his evidence.

73. As we understood it, Dr Ogunsanya's argument was that it was unfair that the various applications made were put on hold. He sought to complain about this on behalf of Dr B by whom he is not instructed. In our view this is, to say the least, irregular. We do not consider that the mantle of being an officer of the court permits an advocate to advance a case alleging a breach of human rights on behalf of someone by whom he is not instructed - except in particular circumstances that do not apply here. In our view this was a last-ditch attempt to breathe some life into the case originally advanced regarding partnership law, most of which was ultimately conceded,

74. Much is made of the fact that the CQC knew that the practice did not have a registered manager and/or that two partners had left and/or that it transpired that the FGP had not, in fact, applied for a variation of location to cover their caretaker role at Morum House. We do not consider that these points materially assist the Appellant. The statutory duty on the Respondent is to take enforcement action *only where it is needed*. A responsible regulator is entitled to take the view that action would be unnecessary or disproportionate. In our view it also made complete regulatory sense in the context of impending inspection in May that the applications made in April were on hold. The fact is that the registration was suspended in May 2018. We do not consider there is any or any material conflict or inconsistency between the law, the Respondent's policy, and how the various applications were processed in this appeal.

75. We do not consider that it is necessary to make any specific findings regarding Mr Ogunsanya's submission regarding partnership law but we make the following observations. No formal evidence has been adduced as to any dissolution. The Appellant's case is that it was a partnership at will which was dissolved at will when Drs S and B resigned. It appears to us that, if and in so far as there was any dissolution, it was a technical rather than a formal dissolution. In our view the issue regarding partnership law has no bearing on the issue of enforcement action available to the Respondent in any event. It was suggested that the CQC did not have a policy regarding dissolution of partnerships. In our view the existing practice and the published policy regarding how changes to registration are to be effected and considered was (and is) in accordance with

the law, including section 19 of the Act, and were entirely sensible in the regulatory context. The policy amply covered the situation in this case.

76. The fact that the high threshold applicable for urgent cancellation under section 30 was (and is still) met does not mean that the power of cancellation should necessarily be exercised. We have a discretion which must be exercised in accordance with the principle of proportionality.

77. Curiously the only reference to Article 8 in this appeal was made by reference to a doctor who is not represented by Dr Ogunsanya. We noted that Article one of Protocol One was referred to in the claim lodged in the Queen's Bench Division but no discrete arguments were placed before us regarding any protected interests on the part of Drs Agoe and Ali. Notwithstanding this we are willing to assume for present purposes that the interests of Drs Agoe and Ali are part of their private and business life interests and the inference involved in the decision are such as to merit the protection of their interests under the ECHR by reference to Article 8 and Article One of Protocol One.

78. The Respondent has satisfied us that the decision taken was in accordance with the Health and Social Care Act 2008 and with the law. We are also satisfied that the decision was justified and necessary in order to protect the public interest in the protection of the health, safety and well-being of patients and the maintenance and promotion of public confidence in the system of regulation.

79. In reaching our decision on the issue of proportionality, we took into account that the impact of the cancellation was very serious. The practice that Drs Agoe and Ali wished to continue, and to develop by bringing in new partners, was brought to an immediate end when the Magistrate's order was made.

80. We recognise that when assessing proportionality alternatives to the most serious regulatory response should be considered. In our view there were no other options such as warning notice(s) or conditions because the practice was already suspended.

81. We have balanced the impact of the decision upon the Appellant's interests as against the public interest. We consider that the facets of the public interest engaged far outweigh the interests of Dr Agoe and Dr Ali and any other person affected. In our view the decision to cancel registration was (and remains) reasonable, necessary and proportionate.

Decision

The decision to cancel registration on an urgent basis is confirmed and the appeal is dismissed.

Tribunal Judge Siobhan Goodrich

First-tier Tribunal (Health Education and Social Care)

4 February 2019